AzHHA QUESTIONS FOR ADHS
EMERGENCY DEPARTMENT CAPACITY/OVERCROWDING
Arizona Department of Health Services
March 10, 2006
www.azdhs.gov

The following information is provided by the Arizona Department of Health Services in response to questions from the Arizona Hospital and Healthcare Association in order to assist hospitals with planning for "overcapacity" (exceeding licensed capacity.) The following information is intended to provide general guidance and may not be construed as a final legal determination by the Department with regard to a specific situation. The Department will continue to evaluate each situation that may arise on a case-by-case basis for purposes of ensuring compliance with applicable state and federal laws, rules and regulations.

There is a distinction between anticipated seasonal increases in demands for hospital services and public health emergencies. The Department's Bureau of Emergency Preparedness and Response provides for the implementation of a Hospital Surge Capacity and Capability Plan during public health emergencies. The Department is not addressing this plan; rather it is responding to the issue of exceeding licensed capacity in high-demand, non-emergency situations.

ADHS LICENSING QUESTIONS

A. Policies and Procedures

1. Hospitals request additional guidance on ADHS' expectations for hospital preparedness and the content and execution of hospital diversion and disaster plans.
Answer:
When preparing and executing its plans, each hospital must take into consideration the scope and services provided by the hospital, the community needs and resources and compliance with state rules. (See A.A.C. R9-10-231, Disaster Management, A.A.C. R9-10-216, Emergency Services, and A.A.C. R9-10-203.C.1.g, Diversion.)

2. To what extent can a hospital's diversion or disaster plan override state regulatory requirements when the hospital is overcapacity? In other words, can the hospital's disaster plan call for measures that would ordinarily conflict with state licensure requirements?
Answer:
The hospital's diversion or disaster plan cannot override state regulatory requirements when the hospital exceeds licensed capacity. The hospital's diversion or disaster plan must be established and have the ability to be implemented within the ADHS licensing requirements. The only time the hospital would be exempt from meeting the requirements of licensing would be when the Governor declared a state/national disaster with temporary waivers of health care institution licensing requirements under A.R.S. § 36-787(A)(7).

3. Would ADHS be willing to review recommendations from an AzHHA task force devoted to emergency department capacity issues and "pre-approve" a model disaster plan prepared by this task force?

Answer:

The Division of Licensing (Division) is certainly open to providing technical assistance and this can be accomplished through various methods:

a. ADHS has provided technical assistance to individual hospitals related to the review of policies and procedures that are required through the statutes and/or hospital rules. This has been done for exceeding licensed capacity and diversion process both formally and informally in recent months.

b. In recent months, the Division has also been available to provide technical assistance at the time a facility is exceeding licensed capacity and in need of additional resources and/or confirmation that alternative care resources were appropriate for the facility to utilize. If a hospital were to have a unique situation or a situation that the hospital felt required some review by ADHS, the Department is available. The phone number was communicated in a memo sent in December 2005. However, the Department would like to make sure that providers know they can reach a specific Division Assistant Director by calling the 24-hour line for Epidemiology and Disease Control. The number is (602) 364-4562.

c. The Division continues to give technical assistance and answer questions on an informal basis by phone.

d. The Division could review a model disaster plan prepared by the task force through a technical assistance process. However, it should be kept in mind that increased seasonal demand for hospital services is not a disaster as defined in A.A.C. R9-10-201(30). This model plan would not be required by ADHS. Please note that each hospital desiring to implement the plan would have to adopt the plan under A.A.C. R9-10-203(C)(1)(g). A review of each hospital's plan would occur at licensing or relicensing, or as technical assistance at the request of the provider.

B. <u>Enforcement</u>

1. What is ADHS' enforcement policy when a hospital violates a state licensure requirement due to overcapacity? Does ADHS take the fact that the hospital was overcapacity into account as a mitigating circumstance in a licensure survey or enforcement proceeding?

Answer:

The Department's primary response to a rule violation is to issue a Statement of Deficiency. When the scope and severity of the violations warrant it, the Department may take enforcement action. The Department may take into consideration the circumstances leading to a hospital exceeding licensed capacity and its efforts to mitigate those circumstances in determining whether or to what extent to take enforcement action.

2. Does ADHS prefer (or require) that hospitals notify ADHS when hospitals are in an overcapacity situation?

Answer:

The rules do not require that hospitals notify ADHS when they exceed licensed capacity, although hospitals may do so if they wish. Hospitals may contact ADHS for technical assistance when they are exceeding licensed capacity.

C. Overflow Patients

1. How much flexibility do hospitals have to "overflow" patients into different beds/units when overcapacity (e.g., in overcapacity situations, can hospitals place adults in pediatric beds, women who are not OB/Gyn patients in an OB/Gyn beds)?

Answer:

In circumstances when the hospital is exceeding licensed capacity, please refer to A.A.C. R9-10-203(C)(5), A.A.C. R9-10-204 (B)(1)(e), and A.A.C. R9-10-208(C)(4). Within these guidelines, the Department strives to provide as much flexibility to hospitals as possible while protecting the health and safety of patients in each situation.

2. Can hospitals create "new" overflow units in hospital space (e.g., turn a rehabilitation unit or pain clinic into an overflow emergency department or inpatient unit; convert a telemetry unit into a temporary ICU) when they are overcapacity without ADHS pre-approval? If so, what are the licensure requirements for this space (e.g., space in the main hospital building, space licensed under the hospital's group license) or applicable restrictions? If ADHS requires pre-approval, what is the pre-approval process for creating overflow beds or units and how quickly will ADHS respond to hospital requests for pre-approval?

Answer:

In circumstances when the hospital is exceeding licensed capacity, please refer to A.A.C. R9-10-203(C)(5), A.A.C. R9-10-204 (B)(1)(e), and A.A.C. R9-10-208(C)(4). Within these guidelines, the Department strives to provide as much flexibility to hospitals as possible while protecting the health and safety of patients in each situation. ADHS can provide technical assistance to hospitals upon request.

3. Can hospitals use cots purchased with HRSA bioterrorism grant monies for surge capacity when there is not a declared state of emergency?

Answer:

No. Under the Department's surge capacity plan (posted at www.azdhs.gov/pandemicflu), HRSA purchased materials can only be used after tier 2, a Governor-declared State of Emergency.

4. Can hospitals set up triage tents outside of the hospital's emergency department in an overcapacity situation to provide emergency department triage and medical screening examination services?

Answer:

If all other options have been exhausted, the hospital may expand its emergency department beyond licensed space. The hospital must ensure that hospital personnel

provide a medical screening/assessment to each patient that presents.

5. Can hospitals place emergency department patients or inpatients in hallways on inpatient floors so that patients can be divided among the hospital's inpatient and outpatient units? It is our understanding that this practice is permitted in other states (e.g., New Jersey).

Answer:

In circumstances when the hospital is exceeding licensed capacity, please refer to A.A.C. R9-10-203(C)(5), A.A.C. R9-10-204 (B)(1)(e), and A.A.C. R9-10-208(C)(4). Within these guidelines, the Department strives to provide as much flexibility to hospitals as possible while protecting the health and safety of patients in each situation.

D. Staffing

1. What are ADHS' expectations for acuity staffing when the hospital is overcapacity? What if the hospital cannot bring any additional staff members after documented attempts and patient transfer to other hospitals is not an option? What are ADHS' ICU staffing expectations in an overcapacity situation when the hospital has tried to, but cannot, bring in sufficient staff to meet the ICU ratios and acuities staffing requirements?

Answer:

The rules provide that the hospital determine the patient needs and adjust the number and type of personnel to meet those needs. There is no exception to this rule, nor can ADHS waive this rule. There is also no exception to or ability to waive the ICU ratios. If all efforts to comply have been exhausted by the hospital, this will be taken into consideration by ADHS as a mitigating factor.

2. Can hospitals ask EMS personnel to provide staff assistance with hospital patients when they are over capacity? More specifically, may EMS personnel, with appropriate supervision and consistent with their scope of practice, provide care to hospital patients (e.g., patients that EMS personnel have transported to the hospital) even if they are not credentialed by the hospital in overcapacity situations? Are there any restrictions on a hospital's use of EMS personnel in an overcapacity situation?

Answer:

The hospital rules and the EMS rules do not prevent EMS personnel from participating in the care of patients in the hospital. The care provided to patients once they arrive must be consistent with hospital policies and procedures and the same for all patients. EMS rules to consider:

a. Under A.A.C. R9-25-201, the general rules require that an EMT-B with advanced procedures, EMT-I, and EMT-P, cannot practice their skills unless they are under administrative medical direction and is able to receive on-line medical direction. The rules for administrative medical direction and on-line medical direction are R9-25-202 and 203.

b. When an Arizona Certified Paramedic functions in the certification role within the defined scope of practice the paramedic must be under the on-line direction of a physician who is privileged and actively practices emergency medicine.

3. What is a hospital's responsibility when its on-call surgeons refuse to perform surgery on emergency patients because the hospital's ICU is overcapacity?

Answer:

A hospital is required to provide emergency services under A.A.C. R-9-10-216. If emergency services cannot be provided, subsection (A)(5) provides that measures and procedures must be implemented to minimize risk to the patient until the patient is transported or transferred to another hospital.

E. Hospital Closure/Patient Diversion

1. What does it mean for a hospital to "close" from ADHS' perspective? Is continuing to provide care, but not accepting new patients a "closure"? Does ADHS distinguish between a hospital's ability to close to inpatients versus emergency department patients?

Answer:

ADHS requires that as long as the hospital has available licensed beds, a safe environment and adequate resources, the hospital must continue to accept inpatients based on the hospital's scope of services. Once a hospital is at licensed capacity it cannot admit inpatients except for emergency admissions.

A hospital must provide emergency services 24 hours a day. The hospital is required to have a diversion policy and procedure and this policy and procedure can be implemented based upon the initiation of the hospital's protocols to do so. The hospital can also discharge patients, cancel elective surgeries, and transfer patients to other health care facilities.

2. Under what circumstances is it acceptable for a hospital to "close" (under ADHS' definition) or refuse to accept new patients (e.g., flood, anthrax scare, overcapacity situations)?

Answer:

The hospital cannot deny access to services to any patient presenting for emergency medical services, unless a disaster occurs which makes it impossible for the hospital to provide services.

3. Can a hospital place signage on its property to notify patients that it is overcapacity? Can the hospital notify emergency department patients of expected wait times when the hospital is overcapacity?

Answer:

According to the Acute Care Hospital EMTALA regulations, the hospital must have signage posted to inform patients that they have the right to a medical screening exam once they present to the hospital requesting emergency services. There are no rules prohibiting or requiring any other signage.

4. What are ADHS' and CMS' expectations with respect to the EMTALA medical screening examinations for patients who likely do not need emergency services and can be triaged to a lower level of care (e.g., an urgent care center)? When determining whether the medical screening examination is sufficient, would the medical screening examination be compared to a typical medical screening examination or compared to medical screening examinations provided in an overcapacity situation?

Answer:

The hospital is required to conduct a medical screening exam for all patients who present to the hospital for emergency services. Once the patient is determined not to have a medical emergency, the patient can be transferred to the level of care that is appropriate for the patient's medical condition. There is only one definition of a medical screening examination. The medical screening examination would be the same for all situations.

F. Patient Transfers

1. What are ADHS' expectations for patient transfers when the hospital is overcapacity? Does ADHS impose any "duty to accept" requirement for patient transfers, and if so, what if the accepting hospital's emergency department is overcapacity?

Answer:

The hospital is obligated to accept transfers when they have the capacity and resources to meet the needs of the patient.

2. Can a hospital that does not have an organized pediatric service admit non-emergent pediatric patients to the hospital when there is no hospital with an organized pediatric service available to accept these patients?

Answer:

A hospital cannot admit non-emergent patients to a service unless they have an established organized service and licensed beds. See A.A.C. R9-10-223(C).

G. Rural/Regional Hospitals

1. What are ADHS' expectations for rural or regional hospitals that have met all regulatory requirements regarding calling in staff, prioritizing emergency admissions, etc., but are still overcapacity? In these situations, ambulances cannot be diverted and frequently, receiving hospitals are also at capacity or overcapacity, so transferring patients to a higher level of care is frequently not an option.

Answer:

ADHS expects that the hospital continue to provide care and services to the patients within the hospital and those patients arriving to the hospital.

2. Canceling scheduled, elective procedures does not always have a significant impact on patient volume and such cancellations may compromise the scheduled patient's care, particularly when the hospital is located in a rural area and is routinely overcapacity. Do hospitals have any flexibility under existing ADHS rules to continue to provide scheduled procedures when the hospital is overcapacity if this is determined to be in the scheduled patient's best interest?

Answer:

The hospital can exceed the capacity of a service only when it is determined that the patient has an emergency medical condition. See A.A.C. R9-10-203(C)(5).

H. EMS Questions

1. What is ADHS' position on ambulance diversion and to what extent can hospitals divert pre-hospital providers when they are overcapacity? Does ADHS' position change if the hospital is participating in a "no diversion" pilot project?

Answer:

ADHS hospital rules require the hospital to have a policy and procedure for diversion. It is expected that hospitals implement the diversion procedure when the hospital is at capacity in the emergency department. ADHS understands that when hospitals go on divert, ambulances may be diverted. There is no regulatory penalty to ambulances who have to divert. As to implementing a no diversion pilot project, ADHS has regulatory and licensing authority over hospitals and has overall responsibility for establishing, coordinating, and administering a system of emergency medical services and trauma care. This project must have ADHS approval before implementation, since it impacts hospitals who are required to have diversion plans and who may be acting outside of their own required plans, and may impact the delivery of emergency medical services and trauma care.

2. We believe that patient choice should not be the deciding factor when a hospital is overcapacity (see AzHHA letter to BEMS, dated July 11, 2005, attached). To the contrary, we believe that the hospital's overcapacity/diversion status should trump patient choice. What is ADHS' position on this issue? Are EMS personnel required to take a patient to the hospital of their choice even when the patient's preferred hospital is on diversion or overcapacity?

Answer:

EMS statutes allow the director to establish protocols for emergency medical providers to refer, advise or transport a patient by the most appropriate means to the most appropriate provider of medical services based on the patient's condition. The protocol adopted by the director, after consultation with the BEMS medical director, the EMS Council and the Medical Direction Counsel, is A.A.C. R9-25-504. That protocol provides that, if a patient's medical condition does not pose an immediate threat to life or limb, patient choice is one of several factors to be considered when determining where to transport the patient. The protocol also requires an emergency medical provider or an ambulance service to notify the ADHS in writing before implementing this protocol, because it triggers record-keeping and records review requirements. The implementation of the

protocol by an emergency medical provider or an ambulance service is optional under R9-25-504.